SUSPECTED ACUTE MI

FIELD ASSESSMENT/TREATMENT INDICATORS

Chest Pain (Typical or Atypical)
Syncopal episode
History of previous AMI
History of heart disease
Angina
Risk Factors

BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI
2. Reduce anxiety, allow patient to assume position of comfort
3. O2 at 4Lmin via NC and titrate as needed
4. May assist patient with self administration of NTG

ALS INTERVENTIONS

1. Obtain rhythm strip for documentation
2. ASA 162mg PO.
3. Consider early vascular access
4. For patients with chest pain, BP< 90mmHg and clear breath sounds give 300ml NS bolus, may repeat
5. **For agencies utilizing 12 Lead Technology *only***:
   a. If patient condition is critical, do not delay transport to obtain EKG
   b. Obtain 12 Lead EKG
   c. If BP< 90mmHg, or if inferior wall infarct is suspected consider obtaining a right-chest 12 lead (V4R).
   d. If right ventricular infarct (RVI) is suspected and BP< 90mmHg, consider 300ml NS bolus, may repeat. Early consultation with Base Hospital or receiving hospital in rural areas is recommended. (Nitrates should be avoided in the presence of suspected RVI or hypotension)
   e. If ST segment abnormalities noted, contact Base Hospital while preparing patient for expeditious transport.
   f. Repeat 12 Lead at regular intervals, but do not delay transport of patient
6. Nitroglycerin 1/150gr SL or NTG spray, may repeat at 3-5minute intervals if BP>90mmHg. Consider MS for pain management when NTG is contraindicated (BP<90mmHg, or recent Viagra use)
7. MS 10mg IV titrated in 1-2mg increments. Consider concurrent administration of NTG with MS if there is no pain relief from the initial NTG administration. Contact Base Hospital for further MS orders
8. Consider establishing a saline lock enroute on same side as initial IV
9. Complete thrombolytic checklist, if time permits.